FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044552

Facility Name: Faith Care Center

Address: 2420 Poplar St. (Number) Highland (City) 62249 (Zip Code)

County: Madison

Telephone Number: 618-654-4600 **Fax #** 618-654-3803

IDPA ID Number: 37-1057583

Date of Initial License for Current Owners: 03/01/1979

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501(c)(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Allan Larson, CPA **Telephone Number:** 314-336-3679

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 5/1/02 to 3/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date) 10/31/03

(Type or Print Name) Mark Robinson

(Title) Executive Director

Paid Preparer

(Signed) (Date)

(Print Name and Title) Allan B. Larson, CPA, Principal

(Firm Name & Address) Larson, Allen, Weishair & Co., LLP, 12801 Flushing Meadows Drive, Suite 100 St. Louis, MO

(Telephone) 314-336-3600 Fax # 314-336-3650

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 5/1/02 Ending: 3/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	62	Intermediate (ICF)	62	20,770	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	62	TOTALS	62	20,770	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	14,191	6,377		20,568	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,191	6,377		20,568	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.03%

D. How many bed-hold days during this year were paid by Public Aid?
161 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Senior Community Meal Program

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 3/1/1979

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 3/1/1979 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 4/30/2003 Fiscal Year: 4/30/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 5/1/02 Ending: 3/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	129,673	8,748	3,465	141,886	18,646	160,532	(25,728)	134,804			1
2	Food Purchase		121,938		121,938	(48,571)	73,367		73,367			2
3	Housekeeping	94,671	13,763	1,362	109,796	(55,233)	54,563		54,563			3
4	Laundry					55,233	55,233		55,233			4
5	Heat and Other Utilities			56,191	56,191		56,191		56,191			5
6	Maintenance	49,102	17,920	3,771	70,793		70,793		70,793			6
7	Other (specify):* trash removal			2,071	2,071		2,071		2,071			7
8	**TOTAL General Services**	273,446	162,369	66,860	502,675	(29,925)	472,750	(25,728)	447,022			8
	B. Health Care and Programs											
9	Medical Director			6,050	6,050		6,050		6,050			9
10	Nursing and Medical Records	777,952	58,244	4,435	840,631	(5,008)	835,623		835,623			10
10a	Therapy											10a
11	Activities	34,197	2,241		36,438		36,438		36,438			11
12	Social Services	31,333	225		31,558		31,558		31,558			12
13	Nurse Aide Training	4,012		430	4,442	4,290	8,732		8,732			13
14	Program Transportation		778		778		778		778			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	847,494	61,488	10,915	919,897	(718)	919,179		919,179			16
	C. General Administration											
17	Administrative	88,560		2,762	91,322		91,322	(1,552)	89,770			17
18	Directors Fees											18
19	Professional Services			8,691	8,691		8,691		8,691			19
20	Dues, Fees, Subscriptions & Promotions			6,611	6,611	2,182	8,793	(3,435)	5,358			20
21	Clerical & General Office Expenses	44,699	16,292	18,518	79,509	(1,858)	77,651		77,651			21
22	Employee Benefits & Payroll Taxes			288,076	288,076	30,319	318,395		318,395			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,529	7,529		7,529		7,529			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			53,684	53,684		53,684		53,684			26
27	Other (specify):*											27
28	**TOTAL General Administration**	133,259	16,292	385,871	535,422	30,643	566,065	(4,987)	561,078			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,254,199	240,149	463,646	1,957,994		1,957,994	(30,715)	1,927,279			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Faith Care Center #0044552 Report Period Beginning: 5/1/02 Ending: 3/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			20,536	20,536		20,536		20,536			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,679	1,679		1,679	(1,679)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			22,215	22,215		22,215	(1,679)	20,536			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			181	181		181		181			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			31,713	31,713		31,713		31,713			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			31,894	31,894		31,894		31,894			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,254,199	240,149	517,755	2,012,103		2,012,103	(32,394)	1,979,709			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 5/1/02 Ending: 3/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	25,728	V-1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	1,679	V-32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	1,577	V-20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	1,858	V-20		28
29	Other-Attach Schedule gifts	1,552	V-17		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 32,394		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 32,394		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Faith Care Center

ID# 0044552

Report Period Beginning: 5/1/02

Ending: 3/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Senior Meal Program	$ (25,728)	1	1
2	Interest	(1,679)	32	2
3	Resident and Staff Gifts	(1,552)	17	3
4	Newsletter	(1,023)	20	4
5	Advertising-Promo	(254)	20	5
6	Marketing	(300)	20	6
7	Yellow Page Advertising	(1,858)	20	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(32,394)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Faith Care Center # 0044552 **Report Period Beginning:** 5/1/02 **Ending:** 3/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(25,728)	0	0	0	0	0	0	0	0	0	0	(25,728)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(25,728)	0	0	0	0	0	0	0	0	0	0	(25,728)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(1,552)	0	0	0	0	0	0	0	0	0	0	(1,552)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(3,435)	0	0	0	0	0	0	0	0	0	0	(3,435)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(4,987)	0	0	0	0	0	0	0	0	0	0	(4,987)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(30,715)	0	0	0	0	0	0	0	0	0	0	(30,715)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Faith Care Center # 0044552 **Report Period Beginning:** 5/1/02 **Ending:** 3/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,679)	0	0	0	0	0	0	0	0	0	0	(1,679)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,679)	0	0	0	0	0	0	0	0	0	0	(1,679)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(32,394)	0	0	0	0	0	0	0	0	0	0	(32,394)	45

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 5/1/02 Ending: 3/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 5/1/02 Ending: 3/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 5/1/02 Ending: 3/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 5/1/02 Ending: 3/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Finance charges pd to vendors										1,679	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 1,679	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 1,679	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Faith Care Center # 0044552 **Report Period Beginning:** 5/1/02 **Ending:** 3/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$ #VALUE!	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ #VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1998	8
	1999	9
	2000	10
	2001	11
	2002	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Faith Care Center COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0044552

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 5/1/02 Ending: 3/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,234 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories One

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

FCH Apartments-Phase I, Independent Living 56 units
FCH Apartments-Phase II, Independent Living 28 units
FCH VIllage, Independent Living, 18 units
FCH VIllage Homes, Independent Living, 24 units
FCH Countryside Center, Independent Senior Center

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	14,234	1979	$ 50,000	1
2					2
3	TOTALS	14,234		$ 50,000	3

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 5/1/02 Ending: 3/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	62		1979	1979	$ 436,942	$	20	$	$	$ 436,942	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Air Conditioner			1979	22,850		10			22,850	9
10	Heating Units			1980	1,345		10			1,345	10
11	Tile & Windows			1983	6,661		15			6,661	11
12	Wiring			1984	85		25			85	12
13	Fire Alarms			1985	12,505		20			12,505	13
14	A/C & Heater			1985	700		10			700	14
15	Smoke Detector			1985	721		25			721	15
16	Office Addition			1986	9,361	493	20	493		8,417	16
17	Windows			1986	2,930		15			2,930	17
18	Hall C Improvements			1987	1,975		20			1,975	18
19	Roof Repairs			1987	17,886		10			17,886	19
20	Antennae System			1987	2,220		10			2,220	20
21	Floor Tile			1987	933	6	15	6		933	21
22	Shed			1987	2,894	48	15	48		2,894	22
23	2 Heating Units			1979	675		10			675	23
24	Bathroom Improvements			1988	524		10			524	24
25	Front Lights			1988	513		10			513	25
26	Parking Lot Lights			1988	1,915	128	15	128		1,852	26
27	Rear Entrance Enclosure			1988	719	29	25	29		415	27
28	2 Exit Signs			1988	401		12			401	28
29	Shampoo Bowl			1989	280		10			280	29
30	Fan/Light			1989	116		10			116	30
31	Cabinets			1989	856	43	20	43		589	31
32	Arco Glass			1989	56		10			56	32
33	Beauty Shop			1989	474		10			474	33
34	Front Sidewalk			1989	736	37	20	37		497	34
35	Compressor			1989	326	22	15	22		296	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 5/1/02 Ending: 3/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Wall Units-A/C	1989	$ 1,480	$ 99	15	$ 99	$	$ 1,340	37
38	Dietary Cooler	1990	1,533	77	20	77		1,016	38
39	Air Conditioner	1990	3,773		10			3,773	39
40	Sprinkler System	1990	2,141		5			2,141	40
41	Disconnect Box	1990	489		10			489	41
42	Door Holders & Closures	1991	1,425		10			1,425	42
43	Floor Tile	1991	385	25	15	25		299	43
44	Carpet	1992	4,298		5			4,298	44
45	Carpet	1992	981		5			981	45
46	Dining Room Upgrades	1992	17,098	570	30	570		6,317	46
47	Landscape-Courtyard	1992	2,155	35	10	35		2,155	47
48	Nurses' Station Upgrades	1992	2,404	120	20	120		1,322	48
49	Patio Door	1992	301	20	15	20		212	49
50	Awnings	1992	1,573	105	15	105		1,119	50
51	Walkway Landscape	1993	5,814	581	10	581		5,765	51
52	Benches	1993	783	52	15	52		513	52
53	Interior Paint	1993	285		5			285	53
54	Dining/Living Room Upgrades	1994	6,440	258	25	258		2,276	54
55	Floor Coverings	1994	13,354		5			13,354	55
56	Electrical Work	1994	1,352	68	20	68		592	56
57	Exterior Paint	1994	5,860	391	15	391		3,289	57
58	Wallcoverings	1994	1,355	91	15	91		768	58
59	Staff Room Remodel	1995	900	36	25	36		297	59
60	Paint/Paper Resident Rooms	1995	15,681	627	25	627		4,861	60
61	Vinyl Flooring	1996	685		5			685	61
62	Roof Replacement	1996	11,500	575	20	575		3,738	62
63	Air Conditioners (GE)	1997	1,800	225	7	225		1,294	63
64	Paint/Wallpaper Halls	1998	1,150	77	15	77		383	64
65	Paint/Border Halls	1998	583	117	5	117		573	65
66	Shed Improvements (Freezer)	1998	368	24	15	24		118	66
67	Sidewalk to Shed	1999	825	118	7	118		481	67
68	Bathroom Improvements	2000	12,097	1,209	10	1,209		4,234	68
69	Paint Resident Rooms	2000	8,100	1,620	5	1,620		5,805	69
70	TOTAL (lines 4 thru 69)		$ 656,567	$ 7,926		$ 7,926	$	$ 601,950	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 5/1/02 Ending: 3/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 656,567	$ 7,926		$ 7,926	$	$ 601,950	1
2	Carpet Living Room	2000	12,167	2,433	5	2,433		7,705	2
3	Fire Panel Repairs	2001	2,329	155	15	155		426	3
4	Fire Suppression System	2002	1,540	154	8	154		205	4
5	Parking Lot Asphalting	2003	7,500	687	10	687		687	5
6									6
7	April 2003 Depreciation Expense Deducted			(912)		(912)		(912)	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 680,103	$ 10,443		$ 10,443	$	$ 610,061	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 5/1/02 Ending: 3/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 101,909	$ 9,369	$ 9,369	$		$ 61,520	71
72	Current Year Purchases	794	73	73			73	72
73	Fully Depreciated Assets	176,069	323	323			176,069	73
74								74
75	TOTALS	$ 278,772	$ 9,765	$ 9,765	$		$ 237,662	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	1997 Van	1997	$ 35,436	$	$	$	5	$ 35,436	76
77	Maintenance	Truck	1998	2,682	328	328		5	2,652	77
78										78
79										79
80	TOTALS			$ 38,118	$ 328	$ 328	$		$ 38,088	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,046,993	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 20,536	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 20,536	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 885,811	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 5/1/02 Ending: 3/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [x] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [x]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 88

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [x]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies			161		161
3	Classroom Wages	(a)		2,731		2,731
4	Clinical Wages	(b)		1,281		1,281
5	In-House Trainer Wages	(c)		4,290		4,290
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests			269		269
9	TOTALS		$	$ 8,732	$	$ 8,732
10	SUM OF line 9, col. 1 and 2	(e)	$ 8,732			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	4
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	4

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Faith Care Center # 0044552 **Report Period Beginning:** 5/1/02 **Ending:** 3/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 3/31/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 35,000)	384,350		3
4	Supply Inventory (priced at)	.		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 384,350	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	31,000		11
12	Long-Term Investments			12
13	Land	50,000		13
14	Buildings, at Historical Cost	680,103		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	316,890		16
17	Accumulated Depreciation (book methods)	(885,811)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 192,182	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 576,532	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 135,312	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	110,487		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	**Provider Tax Payable**	10,137		36
37	**AP related parties**	30,517		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 286,453	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 286,453	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 290,079	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 576,532	$	48

***(See instructions.)**

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 5/1/02 Ending: 3/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 408,282	1	
2	Restatements (describe):		2	
3	**Adj to beg bal to agree to audit report**	(3)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 408,279	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(118,200)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (118,200)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 290,079	24	*

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,859,170	1
2	Discounts and Allowances for all Levels	(15,000)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,844,170	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	4,524	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	550	13
14	Non-Patient Meals	44,082	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 49,156	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Refunds/Rebates/Miscellaneous	577	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 577	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,893,903	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	502,675	31
32	Health Care	919,897	32
33	General Administration	535,422	33
	B. Capital Expense		
34	Ownership	22,215	34
	C. Ancillary Expense		
35	Special Cost Centers	181	35
36	Provider Participation Fee	31,713	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,012,103	40
41	**Income before Income Taxes (line 30 minus line 40)****	(118,200)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (118,200)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,776	1,982	$ 38,731	$ 19.54	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,940	8,154	143,666	17.62	3
4	Licensed Practical Nurses	10,518	11,963	183,865	15.37	4
5	Nurse Aides & Orderlies	34,975	41,633	371,783	8.93	5
6	Nurse Aide Trainees	744	753	4,012	5.33	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,916	2,045	20,204	9.88	9
10	Activity Assistants	1,343	1,474	13,993	9.49	10
11	Social Service Workers	1,810	2,094	31,333	14.96	11
12	Dietician					12
13	Food Service Supervisor	1,913	2,073	26,922	12.99	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,462	16,466	102,751	6.24	15
16	Dishwashers					16
17	Maintenance Workers	3,909	4,239	49,102	11.58	17
18	Housekeepers	5,958	6,556	47,335	7.22	18
19	Laundry	5,958	6,556	47,335	7.22	19
20	Administrator	2,841	2,994	88,560	29.58	20
21	Assistant Administrator					21
22	Other Administrative	2,585	2,492	13,733	5.51	22
23	Office Manager	327	367	6,625	18.05	23
24	Clerical	2,686	2,877	24,844	8.64	24
25	Vocational Instruction	1,815	1,985	39,405	19.85	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	101,476	116,703	$ 1,254,199 *	$ 10.75	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	120	$ 4,183	1-3	35
36	Medical Director	121	6,050	9-3	36
37	Medical Records Consultant	181	2,352	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	300	10-3	39
40	Physical Therapy Consultant	3	45	10.3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	437	$ 12,930		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mark Robinson	Exec Director	0	$ 34,796
Darlene Genteman	Administrator	0	53,764
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 88,560

B. Administrative - Other

Description	Amount
Staff/Resident Gifts	$ 1,552
Meeting Expenses	1,210
TOTAL (agree to Schedule V, line 17, col. 3)	$ 2,762
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Larson, Allen, Weishair & Co	Audit	$ 8,691
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 8,691

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 65,873
Unemployment Compensation Insurance	3,708
FICA Taxes	110,190
Employee Health Insurance	94,586
Employee Meals	30,643
Illinois Municipal Retirement Fund (IMRF)*	
Uniforms	687
Retirement (401k)	8,776
Physicals	660
Awards	1,080
Tuition Reimbursement	1,718
CPR Cards	85
Quit Smoking Incentive	389
TOTAL (agree to Schedule V, line 22, col.8)	$ 318,395

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	827
Health Care Worker Background Check	
(Indicate # of checks performed 27)	324
Newsletter	884
Advertising/Marketing	1,858
Membership Dues	2,754
Professional Subscriptions/Books	1,592
Marketing	554
Less: Public Relations Expense	(1,023)
Non-allowable advertising	(554)
Yellow page advertising	(1,858)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,358

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
See Attached	7,529
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,529

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 5/1/02 Ending: 3/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
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9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Faith Care Center # 0044552 **Report Period Beginning:** 5/1/02 **Ending:** 3/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. LSN $2754

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 36,625 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 31,713
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 30,643 Has any meal income been offset against related costs? No Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel?
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Larson, Allen, Weishair & Co. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Pending - will forward when complete

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.